HCFA Physician Incentive Plan Summary Data Form
Instructions for Providers

Note: These instructions have been developed as a collaborative effort with representatives of the managed care industry in order to streamline the Summary Data Form completion process and to standardize interpretations of the HCFA regulations by the Managed Care Organizations (MCOs). Physician groups and IPAs should consult their MCO provider relations representatives, contract managers or associations for more details. Additional information is available on HCFA's web site, including an extensive PIP Q & A document. www.hcfa.gov/medicare/physincp/pip-info.htm

At the top of the Disclosure Form, *print the name* of the physician group or IPA and the reporting year.

Check one of the six (6) applicable contractual relationships that are listed. Disclose one type of relationship on each Data Form you complete. Submit as many Forms as you need to represent all of the arrangements that serve the physician group's/IPA's Medicare enrollees under your contract with the specific MCO. Please note that the first three options are not applicable for physician groups and IPAs.

(1) NA MCO to physician group; (2) NA MCO to intermediate entity; (3) NA MCO to individual physician
(4) _____ Intermediate entity to physician group
(5) _____ Intermediate entity to physician
(6) _____ Physician group to physician group
(7) _____ Physician group to physician
(8) _____ Physician to physician
(9) _____ Intermediate entity to intermediate entity

A HCFA prescribed hierarchy of contracts must be followed and must end at the individual physician level. For example, if a physician group contracts with a group of cardiologists on a capitated basis, the hierarchy would include a) the physician group to cardiology group arrangement and then b) the cardiology group to individual physician arrangement. All disclosures relating to one hierarchy of contracts should be stapled together. The following hierarchies have been identified as possible contract arrangements between physician groups and IPAs with their sub contracted providers.

Selection of: **(4) _____ Intermediate Entity to physician group requires a disclosure of:**
(7) _____ Physician group to physician, then there can be selection of: (8) Physician to physician [this is not required]
OR (6) _____ Physician group to physician group
If (6) is selected, you **must** have (7) to disclose incentives to physicians
There can be selection of: (8) _____ Physician to physician [this is not required]

Selection of: **(9) _____ Intermediate entity to intermediate entity requires disclosure of (**The intermediate entity can have multiple contracting arrangements**):**
(4) _____ Intermediate entity to physician group; If (4) is selected, you **must** have(6) Physician group to physician group and/or (7) to disclose incentives to physicians, with the selection of: (8) Physician to physician if applicable [this (8) is not required]; OR
(5) _____ Intermediate entity to physician; If (5) is selected, there can be selection of: (8) ___ Physician to physician [this is not required]

Selection of: **(5) _____ Intermediate entity to individual physician does not require any subcontract.**
There can be selection of: (8) _____ Physician to physician [this is not required]

Selection of: **(6) _____ Physician Group to Physician Group requires disclosure of:**
(7) Physician Group to Physician to disclose incentives to physicians
Then there can be selection of: (8) Physician to physician [this is not required]

Selection of: **(7) _____ Physician Group to Physician does not require any subcontract.**
Then there can be selection of: (8) Physician to physician [this is not required]

Selection of: (8) _____ Physician to Physician does not require any subcontract.

[OR AS OUTLINED BELOW]

A Physician group to physician
B Physician group to physician group, *then* physician group to physician.
C Intermediate entity to physician
D Intermediate entity to physician group, *then* physician group to physician
E Intermediate entity to intermediate entity, *then* intermediate entity to physician group, *then* physician group to physician
F Intermediate entity to intermediate entity, *then* intermediate entity to physician group, *then* physician group to physician group, *then* physician group to physician
G Intermediate entity to physician group, *then* physician group to physician

Single or aggregate disclosure: The Disclosure Form may reflect a *single* incentive arrangement if that is a unique arrangement. However, physician groups/IPAs should *aggregate* information on one Form for contractual arrangements that are substantially the same and stop-loss requirements that are the same.

For example, if a physician group contracts with 100 PCPs under a similar capitation payment that does not pass referral risk of more than 25% of the capitation payment to the PCPs, the physician group should use one Disclosure Form and disclose all 100 PCP contract arrangements on that Form. If a physician group contracts with any number of specialties under a sub cap arrangement using similar capitation methodology (the rates may be different) and does not pass referral risk of more than 25% of the capitation payment to the specialists, the physician group should use one Disclosure Form and disclose all specialty contract arrangements on that Form.

Entering the information: After checking the relationship you are disclosing, follow the directions below:

1. **On line 1.A**., give the name or identifier of a single provider (e.g., the name or code for the intermediate entity, physician group, or individual physician) or the providers who are aggregated for the disclosure. The provider named or identified when this is the party who receives payment under the provider contract to which the Disclosure Form applies. If you are using an identifier for an aggregation of several entities, attach a list of names of the entities. Do not send lists of physician names unless requested by the managed care organization.

   On line 1.B., give number of aggregated providers whose arrangements are being disclosed. (See discussion above.)

   Line 1.C. asks for disclosure of Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHCs). Please distinguish FQHC/RHCs by using a separate Disclosure Form to report each FQHC/RHC, however you may aggregate those with substantially the same incentive arrangements.

   Line 1.D. applies only to physicians of physician groups (selection of #7 contracting type) and asks for a breakout of the number of physicians who are members of the group and those who independently contract with the group. Members are typically owners, partners, or employees of the physician group. The total of these two numbers should equal the number of providers in 1.B.

   Please note that if intermediate entity to intermediate entity is selected on the Disclosure Form (#9), complete items 1.A - 1.C only since stop loss requirements do not apply to intermediate entities. However, fully complete disclosures for the intermediate entity's relationships with provider groups and their physicians (#4 and #7) and/or the intermediate entity's relationships with individual physicians (#5) because stop loss requirements apply to these levels.

2. **Question 2** identifies whether the incentive arrangement transfers <u>any</u> risk. A capitation payment or percent of premium is considered a transfer of risk for this question, even if the payment is for services provided only by the contracting physician or physician group. [Information is found on item 2 of the Worksheet.]

   Check "yes" or "no" as applicable. If "no" is checked, then this disclosure is complete. If "yes" is checked, identify the type of risk transfer; then go to Question 3.

   Risk transfer choices are: "capitation, bonus, withhold, percent of premium or other." *Check the appropriate choice* or choices; more than one choice should be checked if the arrangement has features of each type of risk-sharing.

   Select "Other" a combination of the four types of risk arrangement does not define the arrangement. For the purpose of this Disclosure Form, the obligation for the provider to fund deficits is considered as a "withhold." A bonus for low utilization of referral services is considered to be risk transference.

3. **Question 3** identifies whether risk is transferred for referrals. [This information is found on item 3 of the Worksheet.] *Check "yes" or "no"* as applicable. A bonus for low utilization of hospital, specialist or other services is considered to be a risk for referral services. If "no" is checked, then this disclosure is complete. If "yes" is checked, go to Question 4.

4. **Question 4** identifies the type of risk sharing arrangements for referral care. See #2 above for instructions on identifying risk arrangements. [This information is found on item 4 of the Worksheet.]

5. **Question 5** quantifies the percentage of risk that is potentially ***attributable to referrals*** made by the contracted should for services for which the provider is contracted by the physician group/IPA. This percentage corresponds to the "% Of Total Compensation At Risk For Referrals" from item 5 of the Worksheet. If the percentage is equal to or below 25 %, the arrangement is not considered to be at substantial financial risk and this disclosure is complete. If above 25 %, proceed to Question 6.

   <u>Percent of premium</u> is similar to capitation. If the payment based on % of premium covers referral services without any limit on the costs for referral services, then the entire payment or 100% is at risk for referrals. In the workboxes below, consider % of premium as capitation.

6. Information for **Question 6** about the number of patients is found on item 6 of the Worksheet. As stated in HCFA regulations, any entity that meets all five criteria (below) for the pooling of risk will be allowed to pool that risk in order to determine the amount of stop-loss required by the regulation. If the number of patients is 25,000 or fewer, then go to Question 7. If greater than 25,000, the disclosure is complete.
   (1) Pooling of patients is otherwise consistent with the relevant contracts governing the compensation arrangements for the physician or group (i.e., no contracts can require risk be segmented by MCO or patient category);
   (2) The physician or group is at risk for referral services with respect to each of the categories of patients being pooled;
   (3) The terms of the compensation arrangements permit the physician or group to spread the risk across the categories of patients being pooled (i.e., payments must be held in a common risk pool);
   (4) The distribution of payments to physicians from the risk pool is not calculated separately by patient category (either by MCO or by Medicaid, Medicare, or commercial); and
   (5) The terms of the risk borne by the physician or group are comparable for all categories of patients being pooled.

   Note that pooling and stop-loss requirements applicable to a group <u>cannot</u> be extended to a subcontracting level. For example:
   - *A physician group has greater than 25,000 patients that meet pooling criteria.*
   - *This group contracts with another physician group, which has 25,000 or fewer patients and bears risk for referrals above 25%.*

The first group is exempt from stop-loss requirements; the second group must comply with stop-loss requirements and the MCO must comply with survey requirements.

For purposes of completing this form, it is presumed that specialists would be responsible for all members and thus would pool their members and that they would be reported on one Disclosure Form as a similar arrangement. It is also presumed that if PCPs have similar contract arrangements with each other that their members would be pooled and would be reported on one Disclosure Form as a similar arrangement.

7. **Question 7** asks for the type and the threshold of the stop-loss insurance if stop-loss coverage for the physician group or physician is required. Aggregate insurance is excess loss coverage that accumulates based on total costs of the entire population for which they are at risk and reimburses after the expected total cost exceeds a pre-determined level. Individual insurance is where a specific provider excess loss accumulates based on per member per year claims.

Check the type of stop-loss - aggregate, individual per patient, or other coverage
If *individual* insurance, give the threshold (also called a deductible) as a *dollar amount.*

Also, briefly describe the stop-loss coverage. If there is more than one threshold level, note that there are multiple levels and include an explanation. If *aggregate or other* is checked or there are arrangements that merit explanation, describe the coverage (attach a sheet for additional space).

A description should include whether the coverage is:
(1) Combined (professional and institutional);
(2) Broken down into institutional, professional and other components;
(3) The deductible, co-insurance percentage, maximum liability/pay-out by the policy;
(4) Whether the stop-loss coverage applies to all costs or only the cost of referral services;
(5) Any other key features of the coverage.

HCFA Stop Loss Information: If incentive arrangements place either a physician or physician group at substantial financial risk, there must be aggregate or per patient stop-loss protection. Aggregate stop-loss protection must cover 90% of the costs of referral services that exceed 25% of potential payments. Per patient coverage may be either single combined coverage, or through separate coverage for institutional and professional services. Per patient stop-loss protection must cover at least 90% of the referral costs that exceed the following threshold, or attachment point, amounts:

Panel Size	Combined Institutional & Professional Deductible	Institutional Deductible	Professional Deductible
1-1000	$ 6,000	$10,000	$3,000
1,001 – 5000	$30,000	$40,000	$10,000
5,001 - 8,000	$40,000	$60,000	$15,000
8,001 - 10,000	$75,000	$100,000	$20,000
10,001 – 25,000	$150,000	$200,000	$25,000
> 25,000	None	none	None

*** * * * * * Sign and date the summary disclosure form in the spaces provided. * * * * * ***